

C-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/16/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy x 12 Visits, Lumbar Spine (97110, 97140, G0283)

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Chiropractor
AADEP Certified
Whole Person Certified
TWCC ADL Doctor
Certified Electrodiagnostic Practitioner
Clinical practice 10+ years in Chiropractic WC WH Therapy

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 12/30/08, 1/12/09
ODG Guidelines and Treatment Guidelines
Dr. DC, 2/20/09, 1/7/09, 12/7/08, 11/17/08, 12/17/08
Spine & Rehab, 11/18/06, 2/27/07, 8/26/08, 7/15/08, 7/8/08,
6/10/08, 5/6/08, 4/1/08, 2/26/08, 10/23/07, 1/22/08, 12/4/07, 11/6/07,
12/17/07 12/11/07 10/23/07, 7/17/07, 6/25/07, 5/29/07, 4/19/07, 4/18/07,
3/22/07, 2/27/07
PPE, 8/11/08, 10/2/08, 12/17/07

PATIENT CLINICAL HISTORY SUMMARY

This is a female worker who was injured on xx/xx/xx. Records indicate that she was involved in an explosion and was knocked down to her knees. She injured her ribs, right shoulder,

elbow, neck and back. She was transported to the hospital. The injured employee underwent a series of epidural injections. MRI of the lumbar spine was performed on 11-03-06 and EMG/NCV on 4-13-06. The injured employee has undergone physical therapy, MRI, EMG/NCV, epidural injections, and home therapy. Twelve additional sessions of physical therapy are being requested.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

The injured employee currently does not meet the OD guideline for an additional 12-sessions of physical therapy. The ODG recommends 10 sessions over 8 weeks of physical therapy, which have already been performed. The injured employee does not meet the requirements per ODG and documentation provided does not support additional treatment beyond and outside the OD guidelines. The reviewer finds that medical necessity does not exist for Physical Therapy x 12 Visits, Lumbar Spine (97110, 97140, G0283).

ODG Physical Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface, including assessment after a "six-visit clinical trial"

Lumbar sprains and strains (ICD9 847.2)

10 visits over 8 week

Sprains and strains of unspecified parts of back (ICD9 847)

10 visits over 5 week

Sprains and strains of sacroiliac region (ICD9 846)

Medical treatment: 10 visits over 8 week

Lumbago; Backache, unspecified (ICD9 724.2; 724.5)

9 visits over 8 week

Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8)

Medical treatment: 10 visits over 8 week

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 week

Post-surgical treatment (arthroplasty): 26 visits over 16 week

Post-surgical treatment (fusion, after graft maturity): 34 visits over 16 week

Intervertebral disc disorder with myelopathy (ICD9 722.7)

Medical treatment: 10 visits over 8 weeks

ODG Physical Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface, including assessment after a "six-visit clinical trial"

Cervicalgia (neck pain); Cervical spondylosis (ICD9 723.1; 721.0)

9 visits over 8 week

Sprains and strains of neck (ICD9 847.0)

10 visits over 8 week

Displacement of cervical intervertebral disc (ICD9 722.0)

Medical treatment: 10 visits over 8 week

Post-injection treatment: 1-2 visits over 1 wee

Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 week

Post-surgical treatment (fusion, after graft maturity): 24 visits over 16 weeks

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)